

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14451

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Floyd</i>	Middle <i>ABE</i>	Last <i>Anders</i>	2a. DATE OF DEATH Month <i>October</i>	Doy <i>10</i>	Year <i>1968</i>	2b. HOUR <i>7 A.M.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. S. DATE OF BIRTH <i>July 23, 1904</i>		6. AGE (In years last birthday) <i>64</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Neb.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Hartford</i>		
10. CITY OR TOWN OF DEATH <i>Hause de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Security Guard</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Shoe</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Hartford</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Rt 1, Box 491</i>			
14. FATHER'S NAME First <i>Andrew</i>	Middle <i>Jackson</i>	Last <i>Anders</i>	15. MOTHER'S MAIDEN NAME First <i>Sara</i>	Middle <i>Jane</i>	Lost <i>Anders</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>217-03-3001</i>	17. INFORMANT <i>Wilbur J. Anders, Rt. 1, Box 451, BelAir.</i>		Address <i>Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>1570</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma Head Pancreas</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.		(c) <i>with Osteosarcoma Jawline</i>		<i>6 weeks</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>157X</i>							
19a. DATE OF OPERATION <i>15/7X</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 10, 1968</i> , to <i>Oct. 10, 1968</i> , that (I) (we) lost saw the deceased alive on <i>Oct. 10, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W.H. Sadowsky Jr.</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Oct. 14, 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>W.H. Sadowsky Jr.</i>		22e. ADDRESS <i>504 Lewis St. Hanover</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 12, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Bel Air Memorial Gardens</i>	23d. LOCATION (City or Town) <i>Bel Air</i>	(County) <i>Hartford</i>	(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Howard K. McComas &amp; Son, Abingdon, Md.</i>		25a. KEPT BY REGISTRAR DATE <i>OCT 14 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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1991-03-11 10:00:00

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16481 basic version

version email name version - original version  
16481-03-11 10:00:00 16481-03-11 10:00:00 16481-03-11 10:00:00

original file 16481

modified file name 16481-03-11 10:00:00

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new version file 16481-03-11 10:00:00

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14445

14452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR AM	
<i>Richard Douglas BANKS 3rd</i>				<i>Oct</i>	<i>30</i>	<i>68</i>	<i>68</i>	<i>7A</i>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
<i>Male</i>		<i>Negro</i>		<i>10/19/68</i>		<i>- yrs.</i>				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
<i>Md</i>		<i>USA</i>				<i>HARFORD</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
<i>Havre de Grace</i>		<i>Harfied Memorial Hos</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
<i>Md</i>		<i>Harfied Aberdeen</i>		<i>X</i>		<i>48 Hanover</i>				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
<i>Richard Douglas Banks Jr</i>					<i>Christine Marie Frink</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
		<i>None</i>		<i>Hospital Record</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>SEVERE ACIDOSIS AND ELECTROLYTE IMBALANCE</i>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>ACUTE GASTROENTERITIS.</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <i></i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<i>Possible congenital cystic disease of lung - awaiting histology</i>										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		<i>/</i>		<i>/</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<i>Yes.</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
<i></i>		<i></i>		<i></i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
<i></i>		<i></i>		<i></i>		<i></i>		<i></i>	<i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-29</i> , 19 <i>68</i> , to <i>10-30</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-30</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		<i>Harold Brenner M.D.</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type)		<i>HAROLD BRENNER.</i>		22e. ADDRESS		<i>HARFORD MEMORIAL HOSPITAL</i>		22c. DATE SIGNED		
<i></i>		<i></i>		<i></i>		<i></i>		<i>10-31-68</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)	
<i>Burial</i>		<i>10/31/68</i>		<i>Berkeley Cemetery</i>		<i>Marlboro Harford Md</i>		<i></i>	<i></i>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<i>Elmer E Bullock Havre de Grace Md</i>		<i></i>		<i>NOV 6 1968</i>		<i>Charles Judge</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14453

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1. DECEASED-NAME (Type or print)		First <i>Anna</i>	Middle <i>G.</i>	Last <i>Basley</i>	2a. DATE OF DEATH Month <i>Oct.</i>	Day <i>7</i>	Year <i>68</i>	2b. HOUR P.M. <i>10:40</i>
3. SEX <i>F</i>		4. RACE <i>wh.</i>		S. DATE OF BIRTH <i>6-6-1874</i>	6. AGE (In years last birthday) <i>74 yrs.</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Harford</i>			
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Citizens Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased admitted) STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Havre de Grace</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>250 Alliance St.</i>	
14. FATHER'S NAME <i>James H. Robinson Jr.</i>		First <i>James</i>	Middle <i>H.</i>	Last <i>Robinson</i>	15. MOTHER'S MAIDEN NAME <i>Margaret J. Davis</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <i>220-54-3046</i>		17. INFORMANT <i>Ralph Robinson</i>	ADDRESS <i>250 Alliance St., Havre de Grace, Md.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Pneumonia</i></p> <p>4409</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Arteriosclerosis</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>4500</p>								
19a. DATE OF OPERATION <i>4500</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>1962</i>, 19____, to <i>10-7-1968</i>, that (I) (we) last saw the deceased alive on <i>10-7-1968</i>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>								
22b. SIGNATURE <i>Lucy Finch</i>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10-7-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Lucy Finch</i>		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Angel Hill</i>		23b. DATE <i>10/10/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Angel Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Havre de Grace, Md.</i>		
24. FUNERAL DIRECTOR <i>Connelly &amp; Son</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 14 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Judie Finch</i>				

19428

19428

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

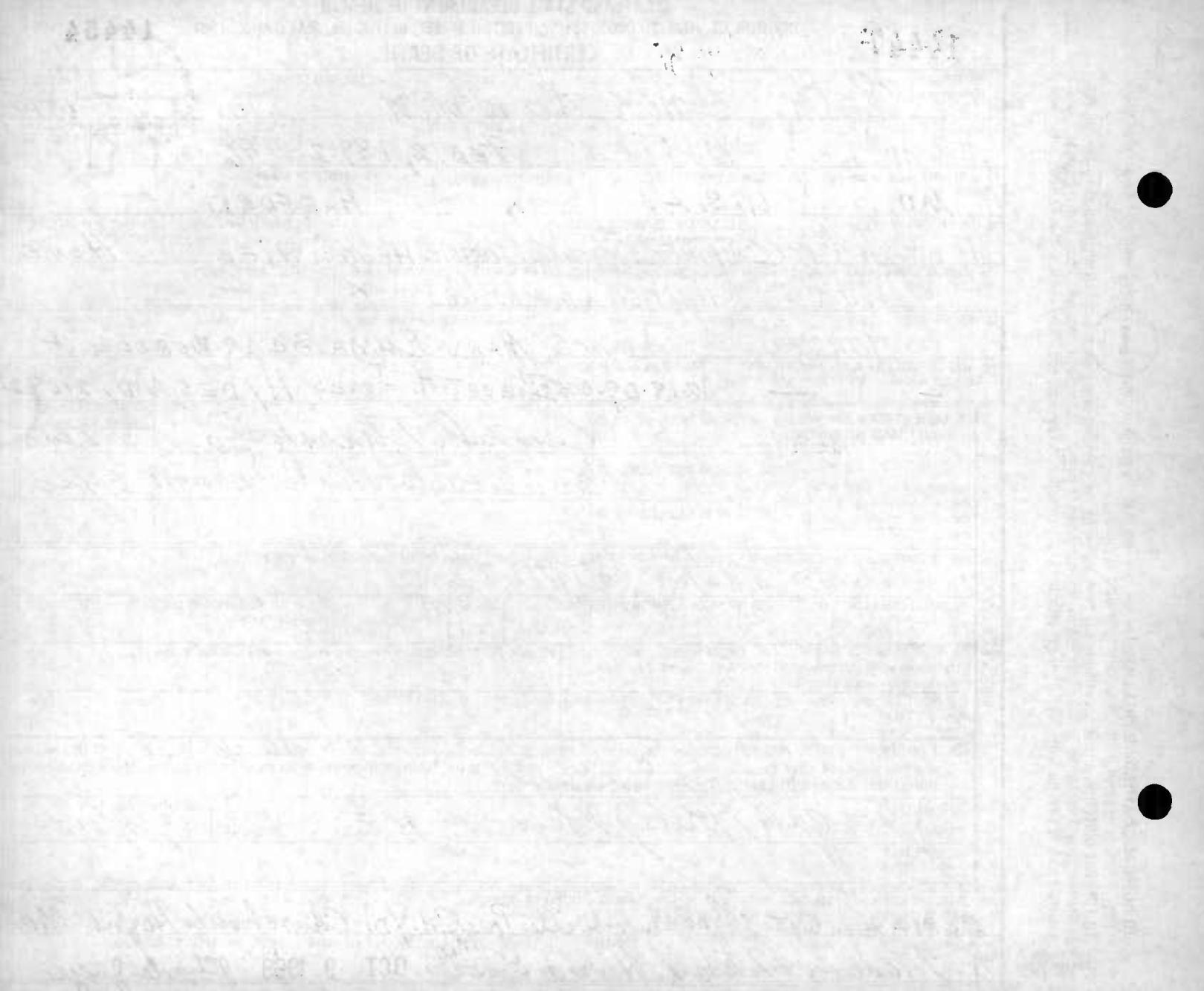
14447 14454

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 10 6 68 10 <sup>33</sup> M	
Ruth Inez Bowman						Month	Day	Year
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female	White	FEB. 2, 1892						
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARFORD					
MD.	U.S.A.							
10. CITY OR TOWN OF DEATH Harriet Grace Hartford Memorial Hospital	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN Churchville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER —				
14. FATHER'S NAME Harvey	First	Middle	Last	15. MOTHER'S MAIDEN NAME Jones	First	Middle	Last	
				MARY EMMA SCARBOROUGH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. 4129	17. INFORMANT RIBERT H. JONES	Address Hydes, MD, 21082		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 6 hrs			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 Diabetes Mellitus								
19a. MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from 9-27, 1968, to 10-6, 1968, that (I) (we) last saw the deceased alive on 10-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Ralph Harley Jr.	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/7/68				
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 9, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Churchville Pres Ch. Yds	23d. LOCATION (City or Town) Churchville	(County) Harford	(State) Md.			
24. FUNERAL DIRECTOR Tr. Madison Mitchell, Harriet Grace	ADDRESS No. 100	25a. REC'D BY REGISTRAR OCT 9 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14455

14448

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Oct 26	2b. HOUR Year	11 A.M.
Shannon Denise BROGAN				Month	26	Year	1968
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		2b. HOUR IF UNDER 24 HRS.
Female	White	Oct 26, 1968		- yrs.	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH				
Md	USA	<input type="checkbox"/> DIVORCED	Harford				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Harford Grace Hospital	Memorial Hosp			Housewife		None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER		
Md.		Harford	114 Bloomsbury	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	114 Bloomsbury Ave.		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
Dennis Francis BROGAN				SANDRA Lee			Sole
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address				
No	None	Lewis J. Brogan	114 Bloomsbury Ave Harford Grace Hospital Md				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity							
DUE TO, OR AS A CONSEQUENCE OF (b) Spontaneous onset of premature labor & intrauterine gestation.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
774X		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
					20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 10-26, 1968, to 10-26, 1968, that (I) (we) last saw the deceased alive on 10-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. G. Hodson							
22d. PHYSICIAN'S NAME (Type)		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/26/68	
23a. BURIAL, CREMATION, REMOVAL (Specify)							
23b. DATE 10/27/68							
23c. NAME OF CEMETERY OR CREMATORIAL Facilities							
23d. LOCATION (City or Town) Md. Harford							
(County) (State)							
24. FUNERAL DIRECTOR Signature & Dr. Harford Grace Md							
ADDRESS				25a. REC'D BY REGISTRAR DATE OCT 29 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

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2001 P 9730

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14456

14445

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First <b>Milo</b>	Middle <b>Guy</b>	Last <b>Carl</b>	2a. DATE OF DEATH Month <b>October 26, 1968</b>	Year <b>1968</b>	2b. HOUR A.M. <b>12:15</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		S. DATE OF BIRTH <b>October 29, 1874</b>	6. AGE (In years last birthday) <b>93</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <b>Harford County,</b>					
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Harford Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>438 East Broadway</b>				
14. FATHER'S NAME First <b>William</b> Middle <b>Frederick</b> Last <b>Carl</b>		15. MOTHER'S MAIDEN NAME First <b>Sarah</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>087-03-5029</b>		17. INFORMANT (Son) <b>Mr. Robert Carl</b>		Address <b>438 East Broadway Bel Air, Maryland 21014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>4129</b>		DUE TO, OR AS A CONSEQUENCE OF <b>Acute congestive Heart Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. <b>Arterio sclerotic cardio vascular disease</b>		DUE TO, OR AS A CONSEQUENCE OF <b>Tendinitis</b>				<b>over 5 yrs</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <b>422</b>									
19a. DATE OF OPERATION <b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		20a. AUTOPSY? <b>YES</b>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Philip W. Heuman, MD</b>		DEGREE <b>MD.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>Oct. 26, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Philip W. Heuman, MD</b>		22e. ADDRESS <b>307 Hickory Ave., Bel Air, Md. 21014</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>October 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Vestal Hills Memorial Cem.</b>		23d. LOCATION (City or Town) <b>Binghamton, Broome Co., New York</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR <b>DATE OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



Items 18-22a film #40 MARYLAND STATE DEPARTMENT OF HEALTH  
10-31-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14457

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14450

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First <b>JAMES</b>	Middle <b>A.</b>	Lost <b>CRISS</b>	2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/>	Month 19	Day M	Year 1968	2b. HOUR 12:35 P M		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Feb. 2, 1920</b>	6. AGE (in years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>October</b>	Day <b>16, 1968</b>	2d. HOUR 12:35 P M
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <b>HARFORD</b>							
10. CITY OR TOWN OF DEATH <b>Bel Air</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>end of Bonnie Drive at Shawnee Lane</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tire business</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Bel Air</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <b>104 Churchville Road</b>						
14. FATHER'S NAME <b>Charles</b>	First <b>E.</b>	Middle <b>Criss</b>	Lost	15. MOTHER'S MAIDEN NAME <b>Onatia</b>	First	Middle	Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>WW 2</b>	16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Combined effects of Doriden &amp; Ethanol</b>  9509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)	17. INFORMANT <b>Mr. Jeremy F. Criss,</b>	ADDRESS <b>Sykesville, Md.</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Combined effects of Doriden &amp; Ethanol</b>  9509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  9708										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. ? 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  <b>Took overdose</b>		21d. LOCATION Street or R.F.D. No. <b>End of Bonnie Drive</b> City or Town <b>at Shawnee Lane, Bel Air</b> County <b>Harford</b> State					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Backyard</b>								
22a. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Charles S. Springate</i>		EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>October 17, 1968</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>										
23b. DATE <b>10/18/68.</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Greenmount Crematory</b>		23d. LOCATION (City or Town) <b>Baltimore, Md.</b>		(County)  <b>Baltimore, Md.</b>		(State)		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS		25. RECEIVED BY REGISTRAR <b>OCT 18 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles S. Springate</i>					
VR AT SME (5) 10M REV. 1/68										

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14458

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Rosann R.	Middle	Last Doak.	2o. DATE OF DEATH Month 10 Day 23 Year 1968	2b. HOUR 5 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4/10/1896		6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Pa	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH House of Grace Harford Memorial Hospital	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md	13b. COUNTY Cecil	13c. CITY OR TOWN Perry Point	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1130 Ave. C	
14. FATHER'S NAME Lawrence R.	First Conley	Middle	15. MOTHER'S MAIDEN NAME Ellen A	Middle Boyle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO. (If you give war or dates of service)	16c. INFORMANT 165-01-8652 Miss Loretta Doak, Perry Point Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 436.9 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerosis and</u> 5 yr. last. (c) <u>Diabetes</u> 5 yr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 331X					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>June 17, 1968</u> , to <u>10/23, 1968</u> , that (I) (we) last saw the deceased alive on <u>10/23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dudley Phillips	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/23/68	
22b. PHYSICIAN'S NAME (Type) Dudley Phillips MD	22e. ADDRESS Dorchester Md				
23b. PUBLIC CREMATION REMOVAL (Specify) Funeral	23b. DATE 10/24/1968 St Charles Cem.	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City or Town) Calverton	(County) Prince George's Co.	(State) Md
24. FUNERAL DIRECTOR See A. Pappas Dr., Perryville, Md.	25a. REC'D BY REGISTRAR OCT 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be presented within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First <i>Charles</i>	Middle <i>-</i>	Lost <i>Duvoisin</i>	2a. DATE OF DEATH Month <i>October</i>	Day <i>15</i>	Year <i>1968</i>	2b. HOUR <i>5 AM</i>
3. SEX <i>Male</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>April 13, 1891</i>		6. AGE (In years lost birthday) <i>77 yrs.</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>PA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i>		
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Mem. Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>SEAFESTMAN</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Chemical Drug</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>704 Winans Way</i>		
14. FATHER'S NAME First <i>Jules</i>		Middle <i>Edward</i>	Lost <i>Duvoisin</i>	15. MOTHER'S MAIDEN NAME First <i>Bertha</i>		Middle <i>Kunzlo</i>	Lost <i></i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>WW#1</i>		17. INFORMANT Lot# <i>566-0125</i>		Address <i>Mrs. Elsie V. Duvoisin 704 Winans Way Baltimore, Maryland 21229</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>								
<p><b>IB. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Anemia</i></p> <p>600x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o). (b) <i>benign prostatic hypertrophy</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause lost. (c) <i></i></p>								
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p> <p>610x <i>Anemia</i></p>								
19a. DATE OF OPERATION <i>6/10/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>9-28</i>, 1968, to <i>10-15</i>, 1968, that (I) (we) last saw the deceased alive on <i>10-15</i>, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>								
22b. SIGNATURE <i>Wiford A. Council Jr. M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/15/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Joseph William Foster</i>		22e. ADDRESS <i>W. Broadway &amp; Williams Street Bel Air, Maryland 21014</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct 18, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Trinity Episcopal Ch. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Churchville, Harford Co., Maryland</i>			
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		ADDRESS <i>W. Broadway &amp; Williams Street Bel Air, Maryland 21014</i>		25a. REC'D BY REGISTRAR <i>OCT 17 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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PC 8200 tested various running

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14453 14460

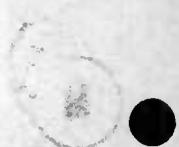
## CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 10 AM	
<i>Florence Sherck Ebel</i>				10	10	66	67 PM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
<i>Female</i>	<i>White</i>	<i>DEC. 18, 1901</i>			<i>66</i> YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH					
<i>Ohio</i>	<i>U.S.A.</i>	<input type="checkbox"/> DIVORCED	<i>Hanford</i>					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
<i>Hanford-Grace Hanford Memorial Hospital</i>	<i>Hanford</i>			<i>HOUSE WIFE</i>			<i>HOME</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
<i>Md.</i>	<i>Hanford</i>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<i>1620 Chapel Rd.</i>					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
<i>John E. Sherck</i>				<i>Matilda MAE</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT			Address			
<i>7969</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pending histology studies</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>7955</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-2, 1968</i> , to <i>10-10, 1968</i> , that (I) (we) last saw the deceased alive on <i>10-10, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Richard J. Cafer MD</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>10/11/68</i>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Cafer</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>Oct. 14, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cem.</i>			23d. LOCATION (City or Town) <i>BALTO.</i>	(County)	(State) <i>MD</i>	
24. FUNERAL DIRECTOR	ADDRESS <i>R. Madison Mitchell, Haven de Gracy MD</i>			25a. REC'D BY REGISTRAR DATE <i>OCT 14 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14461

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First James	Middle Woody	Last Edwards	2a. DATE OF DEATH Month Oct. 12	Year 1968	2b. HOUR 12 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Oct. 17, 1915			6. AGE (In years last birthday) 52	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Harde de Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Mem. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineering Technician			12b. KIND OF BUSINESS OR INDUSTRY US-govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Harford	13c. CITY OR TOWN Edgewood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 321 Crestwood Dr.	Box 218		
14. FATHER'S NAME Guy	First Middle Letcher	Last Edwards	15. MOTHER'S MAIDEN NAME Bessie	First Middle Dona	Last Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 248-07-4471	17. INFORMANT Mrs. Reba Edwards, 321 Crestwood Drive,			Address Edgewood, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Gastrointestinal bleeding and</u> 147X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Carcinoma</u>							
DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma</u> .							
(b) <u>Carcinomatosis</u>							
(c) <u>Carcinoma of the Nasopharynx</u>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
146X							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-10, 1968</u> , to <u>10-12, 1968</u> , that (I) (we) last saw the deceased alive on <u>10-12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dante U. Leonakil, M.D.							
22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS DANTE U. LEONAKIL, M.D.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 14, 1968	23c. NAME OF CEMETERY OR CREMATORIAL AIR Bel Air Memorial Gardens	23d. LOCATION (City or Town) Bel Air	(County)	(State)	Harford	Md
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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It is believed that the first inhabitants of the Americas were Amerindians.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14462

## CERTIFICATE OF DEATH

14455

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

1 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <b>Bessie</b>	Middle	Last <b>Elsey</b>	2a. DATE OF DEATH Month <b>Oct.</b>	Day <b>8</b>	Year <b>68</b>	2b. HOUR PM <b>1:40</b>
3. SEX <b>Female</b>	4. RACE <b>white</b>	S. DATE OF BIRTH <b>08/28/88</b>	6. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR MONTHS <b>0</b>			IF UNDER 24 HRS. DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>W.Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Harford</b>				
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Citizens Nursing Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Churchville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Route # 1, Box 526</b>			
14. FATHER'S NAME First <b>UNK</b>	Middle	Last <b>UNK</b>	15. MOTHER'S MAIDEN NAME First <b>UNK</b>	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. <b>220-52-9954</b>	17. INFORMANT <b>Mrs. Isabel Norris, Churchville, Md</b>	Address <b>Address</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>4129</b> (b) <b>Arteriosclerotic Cerebral</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 yrs</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>plus</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4221 Advance of Rheumatoid Arthritis</b>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ralph H. Holly Jr.</b>	DEGREE <b>Jr.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>10/8/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>None</b>	22e. ADDRESS						
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>10/8/1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>TERRA ALTA Cem.</b>	23d. LOCATION (City or Town) <b>TERRA ALTA</b>	(County) <b>W. Va.</b>	(State) <b>W. Va.</b>		
24. FUNERAL DIRECTOR <b>Pennington Son, Havre de Grace, Md.</b>	ADDRESS	25a. REC'D. BY REGISTRAR <b>OCT 14 1968</b>	26. REGISTRAR'S SIGNATURE <b>Robert J. Judge</b>				

1940



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14456

14463

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or offending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Georgia	Middle Cornelia	Last Ford	2a. DATE OF DEATH Month October	Doy 1	Year 1968	2b. HOUR 10:20 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH January 10, 1884			6. AGE (In years last birthday) 84	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brevin Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Music Teacher		12b. KIND OF BUSINESS OR INDUSTRY Music	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Marylsnd	13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 145 Brannon Road			
14. FATHER'S NAME James	First T.	Middle Ford	Last (D)	15. MOTHER'S MAIDEN NAME Marian Johnson,	Middle (D)	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-50-6171	17. INFORMANT Address Mary Bauer, 145 Brannon Rd. Aberdeen, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN. 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>MYOCARDIAL INSUFFICIENCY</u> YEARS last. (c) <u>ASCUS</u> YEARS.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4701 <u>MALNUTRITION AND FRACTURE K.H.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>Oct 11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Santiago Leyte-Vidal</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-2-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 111 W. Bel Air Ave., Aberdeen, Md. 21001					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3 Oct. 1968	23c. NAME OF CEMETERY OR CREMATORIUM Spesutia Cemetery		23d. LOCATION (City or Town) (County) (State) Perryman, (Harford) Maryland		
24. FUNERAL DIRECTOR <u>Albert Maccohen Jr.</u>		ADDRESS Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE OCT 4 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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FOR STATE  
HEALTH DEPT.

Any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page  
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14457 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14464

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First <b>George</b>	Middle <b>Franklin</b>	Last <b>Harrison, Sr.</b>	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year DEATH ESTI- MATED <input type="checkbox"/> Oct 22 1968	2b. HOUR M		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Aug. 20, 1899</b>	6. AGE (in years at birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <b>Oct</b> Day <b>22</b> Year <b>1968</b>	2d. HOUR A
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Harford County,</b>					
10. CITY OR TOWN OF DEATH <b>Bel Air</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>118 Glenwood Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Merchant - Retail</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Faint</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Bel Air</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <b>118 Glenwood Road</b>			
14. FATHER'S NAME First <b>Samuel Rankin Harrison</b>	Middle	Last	15. MOTHER'S MAIDEN NAME First <b>Anna May Elliott</b>	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>196-07-7552</b>	17. INFORMANT (Wife) <b>Mrs. Helen T. Harrison</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>CORONARY INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 4 YR</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>OVER 2 YRS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>EMPHYSEMA / ALCOHOLISM</b>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town <b>307 Hickory Ave., Bel Air, Md. 21014</b>	County	State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Philip W. Heuman</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>Oct. 22, 1968</b>		
EXAMINER'S NAME (Type) <b>Philip W. Heuman, M.D.</b>	ADDRESS (Street, city, town, or county) <b>307 Hickory Ave., Bel Air, Md. 21014</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 22, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or Town) <b>Bel Air, Harf. Co., Md. 21014</b>	(County)	(State)		
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>	W. Broadway & Williams Bel Air, Md. 21014			25a. REC'D BY REGISTRAR <b>OCT 24 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14465

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

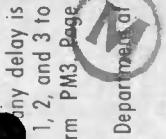
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Ethel</i>	Middle <i>A.</i>	Last <i>Hawkins</i>	2a. DATE OF DEATH Month <i>10</i>	Doy <i>14</i>	Year <i>68</i>	2b. HOUR <i>3:19 P.M.</i>		
3. SEX <i>FEMALE</i>	4. RACE <i>Colored.</i>	S. DATE OF BIRTH <i>November 7, 1932</i>	6. AGE (In years last birthday) <i>25 yrs.</i>	IF UNDER 1 YEAR <i>11</i>	MONTHS <i>7</i>	DAYS <i>0</i>	IF UNDER 24 HRS. <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>Hanford</i>						
10. CITY OR TOWN OF DEATH <i>Hanredde House</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hanford Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Hanford</i>	13c. CITY OR TOWN <i>Hanredde House</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>720 Otisgo St.</i>					
14. FATHER'S NAME First <i>John</i>	Middle <i>X</i>	Last <i>Orkins</i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i>	Middle <i>M</i>	Last <i>Morgan</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>—</i>	16b. SOCIAL SECURITY NO. <i>212-28-8254</i>	17. INFORMANT <i>Mary M. Ramsey</i>	Address <i>734 Otisgo St. Hanredde House, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>493X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>As asthma bronchiale; acute asthmatic exan. Attacks with mictus, continuous since 6 weeks</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>241X</i>									
19a. MEDICAL CERTIFICATION DATE OF OPERATION <i>210</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Mari</i>					DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>10-15-68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>LAJOS Mezci M.D.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/20/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Berkley Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hanredde House, Md.</i>		23e. REG'D BY REGISTRAR ADDRESS <i>Elmer E. Bullock - Hanredde House, Md.</i>	
24. FUNERAL DIRECTOR <i>Elmer E. Bullock - Hanredde House, Md.</i>		25a. REG'D BY REGISTRAR ADDRESS <i>Elmer E. Bullock - Hanredde House, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE OCT 18 1968			

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FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "Pending" in pencil in Item 3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14458 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14466

1. DECEASED NAME (Type or Print)	First	Middle	Last	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
2. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday) YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS			
M	W	25 OCT 37 31	MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD Month Day Year				
Virginia	United States	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Harford	Oct	28	1968	7A M	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace	Osbornes Long			Soldier			Army	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Md.	HARFORD	TOPPA	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	889 Pulaski Highway				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
James W. Haywood				LUCY K. Price				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT			ADDRESS			
Yes Aug 55 - Oct 28	277-34-3063	201 File						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Poisoning due to CO								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9731								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Piped Cat Exhaust into Car			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Osbornewes Farm			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Gerrald E Palmer</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Gerrald E Palmer MD</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) <u>Bethesda Md.</u> <u>10-28-68</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL GARDENS		23d. LOCATION (City or Town) (County) (State)		
Burial		11-1-68		GREEN HILL MEORY RICHLANDS		TAZEWELL VA.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert J. Palmer		GRANT FUNERAL HOME NORTH EAST RD.		DATE OCT 31 1968		Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14467

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <u>Annie</u>	Middle <u>Cox</u>	Last <u>Laurie Hilton</u>	2a. DATE OF DEATH Month <u>October</u>	Day <u>25</u>	Year <u>1968</u>	2b. HOUR <u>4 PM</u>
3. SEX <u>Female</u>		4. RACE <u>White</u>	5. DATE OF BIRTH <u>11/1889</u>		6. AGE (In years last birthday) <u>79</u> YRS.		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>VA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Hartford</u>		
10. CITY OR TOWN OF DEATH <u>Havre de Grace</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Hartford Mem. Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u> COUNTY <u>Hartford</u>		13c. CITY OR TOWN <u>Havre de Grace</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>708 Fountain St.</u>		
14. FATHER'S NAME First <u>Lewis</u> Middle <u>Cox</u> Last		15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Tunes</u> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>		16b. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT <u>Mrs. James Owens</u>		<i>830 Resolution St</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2962</u>		DUE TO, OR AS A CONSEQUENCE OF (b) _____		Respiratory arrest.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) _____		Mental depression.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>309X</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>10</u> MORN <u>19</u> P.M. <u>68</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <u>at work</u>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u>10-13</u>		City or Town <u>Havre de Grace</u>	County <u>Hartford</u>	State <u>Md.</u>
22o. I certify that (I) (this hospital) attended the deceased from <u>10-13, 1968</u> , to <u>10-25, 1968</u> , that (I) (we) last saw the deceased alive on <u>10-25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Lewis</u>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10-25-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Dr. Lewis</u>		22e. ADDRESS <u>10-13, 1968</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/27/68</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Angel Hill</u>		23d. LOCATION (City or Town) <u>Havre de Grace</u> (County) <u>Hartford</u> (State) <u>Md.</u>		
24. FUNERAL DIRECTOR <u>Funeral Director</u>		ADDRESS <u>10-13, 1968</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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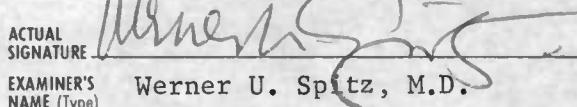
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18535

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)						First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED				Month	Day	Year	2b. HOUR
WILLIAM						CALVERT			October 1 1968				UNKM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	Month	Day	Year	2d. HOUR			
male	white	7-20-1911		57	YEARS	MONTHS	DAYS	HOURS	MIN.	March	24,	1969	UNK M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH								
Maryland		U.S.A.		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Harford								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY							
Edgewood			Kirk Army Hospital - DOA			Lawyer			Law							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER								
Maryland		Baltimore		Roland Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1208 Lake Falls Road								
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last					
William West Holland						Rosalie Eugenia Calvert										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
Yes			WVII			219-01-7070			Mrs. William Holland Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) The Cause of Death cannot be ascertained due 7969 X to advanced decomposition of the body																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 795.5																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY?							
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																
ACTUAL SIGNATURE 													CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.													ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
													DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
													ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town)		(County)	(State)						
Burial		3-27-1969		Greenmount			Baltimore,			Md.						
24. FUNERAL DIRECTOR		H. W. Jenkins & Sons Co., 1905 York Rd. Baltimore, Md. 21212			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
					MAR 27 1969											

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1997-1998 2000

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14468

1. DECEASED-NAME (Type or Print)	First <b>NELLIE</b>	Middle <b>L.</b>	Last <b>JOHNSON</b>	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> Oct 2 1968	2b. HOUR M					
3. SEX <b>Female</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>12/31/89</b>	6. AGE (In years last birthday) <b>78 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month Day Year <b>Oct 2 1968</b>	2d. HOUR M	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Harford</b>							
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Citizens Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Route #1, Gilbert Road</b>						
14. FATHER'S NAME First <b>John</b>	Middle <b>Leight</b>	Last <b>(D)</b>	15. MOTHER'S MAIDEN NAME First <b>Lavinia</b>	Middle <b>Shields</b>	Last <b>(D)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>213-28-0850-D</b>	17. INFORMANT <b>Odessa Hughes, 416 Breslin Rd. Joppatowne</b>	ADDRESS <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture</b> L. Femur <b>887X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9040</b>										
19a. DATE OF OPERATION <b>9040</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fall at home</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Gilbert Rd Aberdeen Md.</b>	21f. LOCATION Street or R.F.D. No. City or Town <b>Gilbert Rd Aberdeen Md.</b>	County <b>Harford</b>	State <b>Md.</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Gerald C Palmer</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>10-2-68</b>				
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>	ADDRESS (Street, city, town, or county) <b>Bel Air, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4 Oct. 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Spesutia Episcopal Cemetery Perryman</b>	23d. LOCATION (City or Town) <b>Perryman</b>	(County) <b>Maryland</b>	(State) <b>Maryland</b>					
24. FUNERAL DIRECTOR <b>Tarring Funeral Home</b>	25a. RECD BY REGISTRAR <b>OCT 4 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						
VR A15ME (5) 10M REV. 1/68 <b>Heister Macomber Jr.</b>										

80281

SOPA 100

2nd year

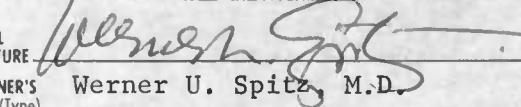
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14462 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14469

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR 3:30 A.M.		
		ADRIAN L.		KING	<input checked="" type="checkbox"/> 10/26/68 19						
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) — YRS.	IF UNDER 1 YEAR MONTHS 4	IF UNDER 24 HRS. DAYS 24	HOURS	MIN.		2d. HOUR 3:30 A.M.		
male	negro	June 2, 1968									
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH							
Maryland	U.S.A.			Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		Harford Memorial Hospital			N/A			N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
Maryland	Harford	Aberdeen	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	EAX 630 Third Street							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
		Lamar		King	Mary		L.	Huff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT	ADDRESS						
NO		** **		Helen Huff, 630 Third St. Aberdeen, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) INTERSTITIAL PNEUMONITIS (SDII)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
484X											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
525X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?						
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Werner U. Spitz, M.D.											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)			(County)	(State)
Burial		28 Oct. 68		Mt. Calvary Cemetery			Aberdeen, (Harford Co.) Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Tarring Funeral Home, Aberdeen, Md. 21001										DATE OCT 28 1968 	

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REVIEW OF THE LITERATURE ON THE

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REPORT

Final

verbal

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sample

ON THE INFLUENCE OF THE WATER POLLUTION ON THE

WATER POLLUTION AND ITS EFFECT ON THE ENVIRONMENT

AND THE ENVIRONMENTAL POLLUTION

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14470

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Joseph</i>	Middle <i></i>	Last <i>King</i>	2a. DATE OF DEATH Month <i>10</i>	Day <i>8</i>	Year <i>68</i>	2b. HOUR <i>5:30 P.M.</i>
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>2/12/1885</i>			6. AGE (In years last birthday) <i>83</i>	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS. DAYS <i></i>
7a. BIRTHPLACE (State or foreign country) <i>N.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Hanford</i>				
10. CITY OR TOWN OF DEATH <i>Hanford Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hanford Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i></i>			12b. KIND OF BUSINESS OR INDUSTRY <i></i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Hanford Believe</i>	13c. CITY OR TOWN <i></i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>Box 44 Rt 1</i>			
14. FATHER'S NAME <i>Lee</i>	First <i></i>	Middle <i></i>	Last <i>King</i>	15. MOTHER'S MAIDEN NAME First <i>Margaret</i>	Middle <i></i>	Last <i></i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>491X</i>	17. INFORMANT <i>Uncle Marion King</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pulmonary Emphysema Chronic Bronchitis</i>			Address <i>Evolution St Hanford Md</i>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>Arteriosclerotic Heart Disease &amp; Longstanding Heart Failure</i>							
19a. DATE OF OPERATION <i></i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>(If either, notify medical examiner)</small>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>		County <i></i>	State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-3</i> , 19 <i>68</i> , to <i>10-8</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-8</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dante U. Monakil, M.D.</i>	DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10-8-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>DANTE U. MONAKIL</i>	22e. ADDRESS <i>211 Union Ave. Hanford Grace</i>						
23a. BURIAL/CREMATION, REMOVAL (Specify) <i></i>	23b. DATE <i>10/11/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Allan Mem. Garden</i>	23d. LOCATION (City or Town) <i>Bell Air Md Hanford</i>	(County) <i></i>	(State) <i></i>		
24. FUNERAL DIRECTOR <i>Emory P. Smith Han. Md</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR DATE <i>OCT 14 1968</i>	25b. REGISTRATION & SIGNATURE <i>Judge</i>				

07/28/1



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First <b>Florence</b>	Middle <b>Edna</b>	Last <b>LaRae</b>	2d. DATE OF DEATH Month <b>October</b> Day <b>20</b> , Year <b>1968</b>	2b. HOURS <b>3:40</b> a.m.		
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>September 28, 1908</b>			6. AGE (in years last birthday) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEP DIVORCED	9. COUNTY OF DEATH <b>Harford</b>					
10. CITY OR TOWN OF DEATH <b>Aberdeen</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route #1,</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>Route #1</b>		
14. FATHER'S NAME First <b>George</b>		Middle <b>W.</b>	Last <b>Shenk (D)</b>	15. MOTHER'S MAIDEN NAME First <b>Mabel</b>		Middle <b>R.</b>	Last <b>Dettinger</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-16-6278</b>		17. INFORMANT <b>Mabel R. Shenk, Route #1, Aberdeen, Md.</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carrying Caecum with</b> <b>1530</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { <b>b)</b> <b>diffuse Metastasis Liver</b> DUE TO, OR AS A CONSEQUENCE OF <b>c)</b>								<b>8 mos</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>1530 Hypertension CVA Disease</b>								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (we) attended the deceased from <b>Oct 16</b> , 1968, to <b>Oct 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 16</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>J. Ralph Horky M.D.</b>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>Oct 20 1968</b>		
23a. PHYSICIAN'S NAME (Type) <b>J. Ralph Horky,</b> M.D.		22e. ADDRESS <b>Churchville, Maryland</b>						
23b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>22 Oct. 68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethel Church Cemetery</b>			23d. LOCATION (City or Town) <b>York County,</b> (County) <b>Pennsylvania</b> (State)		
24. FUNERAL DIRECTOR <b>Walter Neaccombe Sr.</b>		Tarring Funeral Home Aberdeen, Md. 21001			25a. REC'D BY REGISTRAR DATE <b>OCT 23 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Neaccombe</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14472

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1	14465						14472						
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
<i>James Carroll Lee</i>							Month	10	Day	7	Year	68	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR			IF UNDER 24 HRS.		
<i>Male</i>		<i>Negro</i>	<i>July 5, 1890</i>			78 yrs.		MONTHS	3	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED	<input checked="" type="checkbox"/>	DIVORCED	<input type="checkbox"/>	9. COUNTY OF DEATH			
<i>Perryman, Md.</i>		<i>U. S. A.</i>		MARRIED		<input checked="" type="checkbox"/>	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	<i>Harford</i>			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Havre de Grace</i>			<i>451 Lafayette St., Lacover</i>			<i>Laborer</i>			<i>Ordinary U.S.A.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
<i>Md.</i>		<i>Harford</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<i>451 Lafayette Street</i>							
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
<i>Unknown</i>						<i>Rachel</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address <i>451 Lafayette St., Havre de Grace, Md. 21078</i>				
<i>No</i>			<i>218-10-83234</i>			<i>Mrs. Susie V. Lee, Havre de Grace, Md. 21078</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>185X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Metastatic tumor of the prostate gl. (cc.)</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>177X</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Mezei</i> DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22c. DATE SIGNED													
22d. PHYSICIAN'S NAME (Type)		<i>L.I. MEZEI M.D.</i>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City or Town)		(County)	(State)		
<i>Burial</i>		<i>10-11-68</i>		<i>Union Methodist Cem.</i>				<i>Aberdeen, Harford, Md.</i>					
24. FUNERAL DIRECTOR		ADDRESS <i>556 2nd Ave St</i>				25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<i>Otis J. Bullock, Havre de Grace, Md.</i>						<i>OCT 10 1968</i>		<i>Charles Judge</i>					

STAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14473

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.2  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. See 1 and 2  
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1. DECEASED NAME (Type or print)	First <i>Frederick Constantine Lynch</i>	Middle <i></i>	Last <i></i>	2a. DATE OF DEATH Month 10 Day 29 Year 1968 5 45 M	2b. HOUR
3. SEX <i>M</i>	4. RACE <i>W</i>	S. DATE OF BIRTH <i>Sept. 6, 1900</i>	6. AGE (In years last birthday) <i>68</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Harford</i>		
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hartford Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Pattern maker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Airplane Factory</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Bel Air</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>742 Boy 166</i>	
14. FATHER'S NAME <i>Constantine Lynch</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Celeste Wenters</i>	Middle <i></i>	Last <i></i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>212-07-7101</i>	17. INFORMANT <i>Helen E. Lynch, R.D. 2, Bel Air, Md. 21014</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant Adenocarcinoma brain</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Adenocarcinoma prostate with</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>diffuse skeletal metastases</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>172X</i>					
19a. DATE OF OPERATION <i></i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 28, 1968</i> to <i>Oct. 1, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct. 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. Ralph Horkey M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/30/68</i>
22d. PHYSICIAN'S NAME (Type) <i>J. Ralph Horkey</i>	22e. ADDRESS <i></i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11-2-68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore, Maryland</i>	(County) <i>Maryland</i>	(State)
24. FUNERAL DIRECTOR <i>Tabring Funeral Home</i>	ADDRESS <i>Aberdeen, Md. 21001</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 1 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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Item5 FilmG406 11/1/68 14 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14474

1. DECEASED NAME (Type or print)		First <b>Edward</b>	Middle <b>R</b>	Last <b>Mayo, Jr.</b>	2a. DATE OF DEATH Month <b>Oct</b>	Day <b>28</b>	Year <b>1968</b>	2b. HOUR <b>1015AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH <b>27 Oct 1968 1968</b>		6. AGE (In years last birthday) <b>20 YRS.</b>		IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Hawaii</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford</b>					
10. CITY OR TOWN OF DEATH <b>Aberdeen Proving Ground US KIRK ARMY HOSPITAL</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Marine</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>USMC</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Va.</b>		13c. CITY OR TOWN <b>Prince William</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Quantico</b>					
14. FATHER'S NAME First <b>Edward</b>		Middle <b>R</b>	Last <b>Mayo, Sr.</b>	15. MOTHER'S MAIDEN NAME First <b>NA</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>034-34-4855</b>		17. INFORMANT <b>N.T.C.</b>		Address <b>Bainbridge, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain damage</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>819.9</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF <b>Fracture mandible (bilateral),</b> (b) <b>maxilla (L), Right tibia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe laceration posterior scalp</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  <b>8254</b>											
MEDICAL CERTIFICATION	19a. DATE OF OPERATION <b>28 Oct 68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Respiratory Distress</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
	21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. Oct 28 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) <b>Automobile accident</b>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>JFK RT 95 Highway</b>		21f. LOCATION Street or R.F.D. No. <b>Aberdeen</b>		City or Town <b>Harford Maryland</b>		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>28 Oct 68</b> , 1968, to <b>28 Oct 68</b> , 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>28 Oct 68</b> , 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <b>George A. Liebler</b>		22c. DEGREE <b>ATTENDING PHYS.</b>		22d. MED. DIRECTOR <input checked="" type="checkbox"/>		22e. STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>28 Oct 68</b>			
22d. PHYSICIAN'S NAME (Type) <b>GEORGE A LIEBLER CPT MC</b>		22e. ADDRESS <b>US KIRK ARMY HOSP, ABERDEEN PR GR, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-2-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Patrick's</b>		23d. LOCATION (City or Town) <b>Stoneham</b>		(County) <b>Middlesex</b>		(State) <b>Mass.</b>	
24. FUNERAL DIRECTOR <b>Paul R. Crouch</b>		ADDRESS <b>Box 22</b>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 31 1968</b>			
Grant Funeral Home		North East, Md.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Quality Minus

100% Grade A

Class "A" Masonry or Fireproof Stoves

Approved by the U.S. Bureau of Mines

Standardization Board

Manufactured by the Standard Stove Co.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14475

14468

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Velma	Middle DONNA	Last Mc MILLAN	2a. DATE OF DEATH Month October	Day 29	Year 1968	2b. HOUR 30 AM
3. SEX	4. RACE Female	5. DATE OF BIRTH August 31, 1912		6. AGE (In years last birthday) 56	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) VA.	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Harford			
B. MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>				
10. CITY OR TOWN OF DEATH HAUVE de Grace Harford Memorial Hosp	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 807 Fountain Green Rd			
14. FATHER'S NAME GEORGE	First Ellis	Middle V AUGHAN	Lost	15. MOTHER'S MAIDEN NAME GENETTA	First ELLEN	Middle Gilmham	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 227-16-0117	17. INFORMANT (husband) 838-7294 Mr. Earl E. McMillan			Address 807 Fountain Green Road Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Car accident</i> - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca Artery</i> . DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 1750							
19a. DATE OF OPERATION 1750	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca Artery</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>10-17</i> , 1968, to <i>10-29</i> , 1968, that (I) (we) last saw the deceased alive on <i>10-29</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John S. Prender</i>	DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>10/29/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>John S. Prender</i>	22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 31, 1968	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial Gardens</i>	23d. LOCATION (City or Town) (County) (State) <i>Bel Air, Harford Co., Md. 21014</i>				
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>	ADDRESS <i>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 1 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 23d FilmG106 10/68 kk

14476

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First <i>Thomas</i>	Middle <i>S.</i>	Lost <i>Milam</i>	2a. DATE OF DEATH Month <i>October</i>	Doy <i>26</i>	Year <i>1968</i>	2b. HOUR <i>10 A.M.</i>
3. SEX <i>Male</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>7/9/1890</i>		6. AGE (In years last birthday) <i>78</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Hartford</i>			
10. CITY OR TOWN OF DEATH <i>Holyoke Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Congress</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if in institution: Residence before detachment) STATE <i>Holyoke Mass</i>	13b. COUNTY <i>Hartford</i>	13c. CITY OR TOWN <i>Holyoke</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>Congress</i>			
14. FATHER'S NAME First <i>Edward D. Milam</i>	Middle <i></i>	Lost <i></i>	15. MOTHER'S MAIDEN NAME First <i>Rally Watts</i>	Middle <i></i>	Lost <i></i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>225</i>	17. INFORMANT <i>St. John's Church</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>ANXIA</i>							
492X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause <i>PULMONARY EMPHYSEMA</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>PULMONARY EMPHYSEMA</i>							
(c) <i></i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 5271							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>(If either, notify medical examiner)</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED <small>(Enter nature of injury in Part 1 or Part 2, Item 18.)</small>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY <small>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</small>	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-20</i> , 19 <i>68</i> , to <i>10-20</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-20</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John H. H. H.</i>							
22c. DATE SIGNED <i>10-20-68</i>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>N. Wilksboro, N. Carolina</i>					
23a. BURIAL / CREMATION, REMOVAL (Specify)	23b. DATE <i>10/24/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Lawn</i>	23d. LOCATION (City or Town) <i>N. Wilksboro, N. Carolina</i>	(County) <i></i>	(State) <i></i>		
24. FUNERAL DIRECTOR <i>James J. St. John's Chapel, Md.</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i>OCT 23 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Joseph</i>				

6781

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

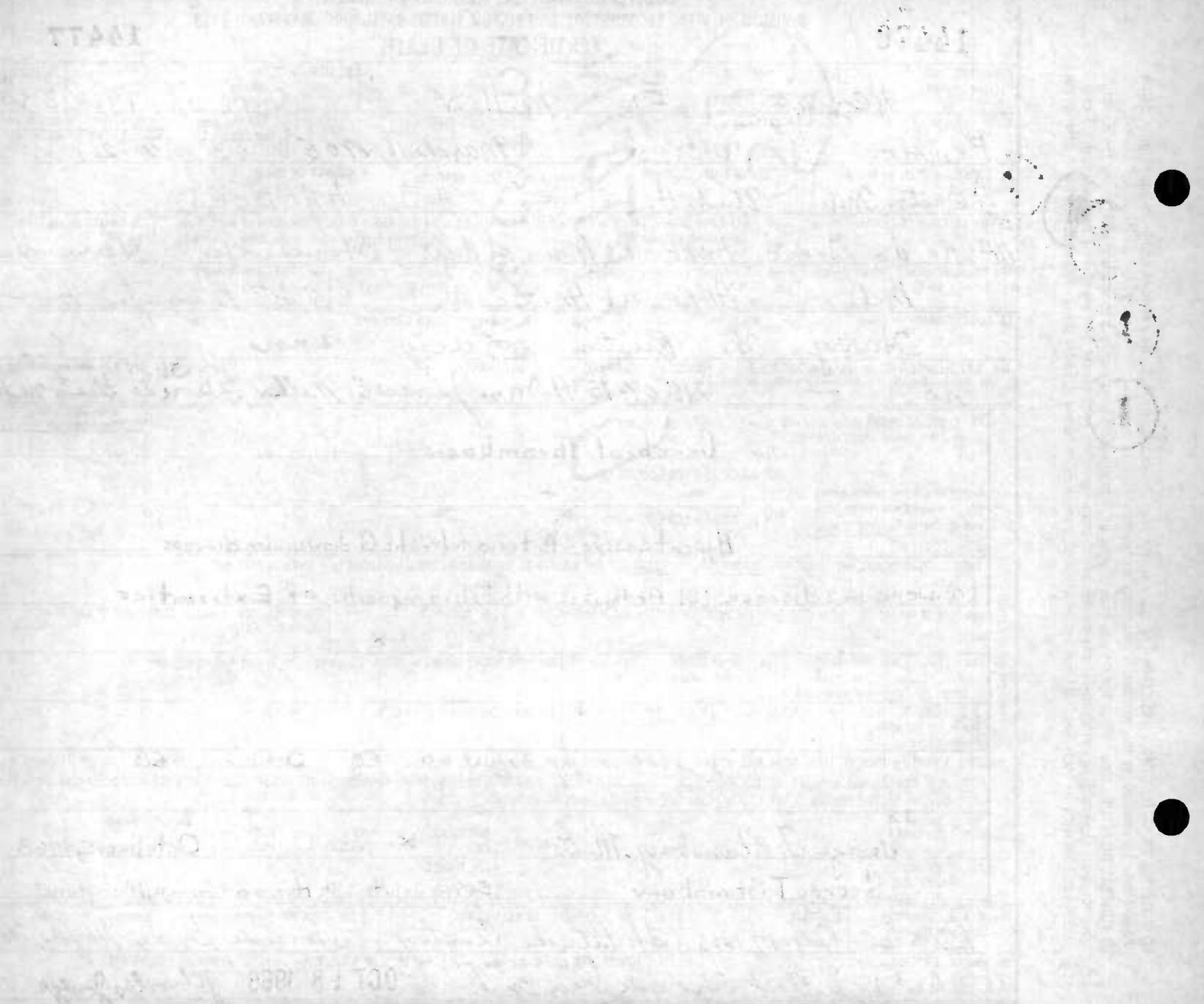
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

14470		14477											
1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR						
<i>Regina</i>		<i>E.</i>	<i>Miller</i>		Month	Doy	Year						
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
<i>Female</i>		<i>colored</i>	<i>March 11, 1905</i>		63 yrs.		MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		NEVER MARRIED	<input type="checkbox"/>	9. COUNTY OF DEATH						
<i>Barto. Md.</i>		<i>U.S.A.</i>	WIDOWED		DIVORCED	<input type="checkbox"/>	<i>HARFORD</i>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
<i>Havre de Grace</i>		<i>HARFORD Memorial Hosp.</i>			<i>Housewife</i>			<i>Housewife</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
<i>Md.</i>		<i>HARFORD</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<i>563 Pennington Ave</i>							
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost				
<i>Harry</i>		<i>W.</i>	<i>Rustin</i>		<i>Lucy</i>		<i>ann</i>			?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>563 Pennington Ave</i>							
(If yes give war or dates of service)		<i>218-09-1541</i>		<i>Mr. James E. Miller, Havre de Grace, Md.</i>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>													
4120 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4438</i>													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <i>Hypertensive-Arteriosclerotic Cardiovascular disease</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
(a) <i>Dercum's disease</i>		(b) <i>Arthritis with Fibromyalgia of Extremities</i>											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <i>August 30, 1968</i> , to <i>October 13, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct. 13, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>George T. Stansbury, M.D.</i>		22c. DATE SIGNED <i>October 15, 1968</i>											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		<i>569 Revolution St. Havre de Grace, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)			
<i>Burial</i>		<i>Oct. 17, 1968</i>		<i>St. Patrick's Cemetery</i>		<i>Havre de Grace, Maryland</i>							
24. FUNERAL DIRECTOR		ADDRESS <i>556 Lewis St.</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<i>Otela J. Bullock, Havre de Grace, Md.</i>													
				DATE <i>OCT 18 1968</i>		<i>Charles Judge</i>							

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

1968



CGP: R-700

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in and funeral director, page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Elsie Gertrude Porter	Middle Lost	2d. DATE OF DEATH Month 10	Day 24	Year 1968	2b. HOUR 8:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH JAN. 18, 1893	6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Harford	IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Harve de Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Harford	13c. CITY OR TOWN Darlington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER P.O.		
14. FATHER'S NAME Louis Conley Jones	15. MOTHER'S MAIDEN NAME Elizabeth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 185-28-864	17. INFORMANT EARL B. HOPKINS, DARLINGTON, MD.	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 days		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular disease 541NS DUE TO, OR AS A CONSEQUENCE OF (c) Vascular disease						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 443x Diabetes mellitus						
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY. OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 10-17, 1968, to 10-24, 1968, that (I) (we) last saw the deceased alive on 10-24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dudley Phillips	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) DARLINGTON, Md 21034	22e. ADDRESS Dudley Phillips					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Oct. 27, 1968	23c. NAME OF CEMETERY OR CREMATORIAL DARLINGTON	23d. LOCATION (City or Town) DARLINGTON, Md.	(County)	(State)	
24. FUNERAL DIRECTOR JOHN H. HARKINS, DELTA, PA.	ADDRESS	25a. REC'D BY REGISTRAR OCT 29 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14472

14479

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Judith	Middle Elizabeth	Lost Ramsey	20. DATE OF DEATH Month Oct	Day 3	Year 1968	2b. HOUR 1215AM	
3. SEX Female	4. RACE Neg	5. DATE OF BIRTH 13 Jan 65		6. AGE (In years lost birthday) 3	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ft Bragg, NC	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford		Md.			
10. CITY OR TOWN OF DEATH Aberdeen Proving Ground	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN APG	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2904 A Garden Drive				
14. FATHER'S NAME First Billy	Middle Ramsey	15. MOTHER'S MAIDEN NAME Margaret	Middle Ann	Lost Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Billy Ramsey, 2904 A Garden Dr., APG, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular collapse</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2825</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sickle Cell Disease Complication</u>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>2926</u>								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2 Oct 1968, to 3 Oct 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3 Oct 1968, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.								
22b. SIGNATURE <u>Ronald B. Rushford</u>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3 Oct 68			
22d. PHYSICIAN'S NAME (Type) RONALD B RUSHFORD, CPT, MC		22e. ADDRESS US KIRK ARMY HOSP, ABERDEEN PG, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4 Oct. 68	23c. NAME OF CEMETERY OR CREMATORIAL Tarring Funeral Home		23d. LOCATION (City or Town) Keyport,	(County) New Jersey	(State)	
24. FUNERAL DIRECTOR <u>Walter W. Neacome Jr.</u>		ADDRESS Aberdeen, Md. 21001	25a. REC'D BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~submitted~~ within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14473

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14480

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First <i>Mary. Lucretia Rawle</i>	Middle <i></i>	Last <i></i>	2a. DATE OF DEATH Month <i>10 27</i>	Day <i>1968</i>	2b. HOUR <i>3:58 P.M.</i>			
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Jan. 13, 1952</i>	6. AGE (In years last birthday) <i>16</i>	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS. DAYS <i></i>	HOURS <i></i>	MIN. <i></i>		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Harford</i>						
10. CITY OR TOWN OF DEATH <i>Harre-de-Grace Harford Memorial Hospital</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Student</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>High School</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Joppa</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>2507 Old Joppa Rd.</i>					
14. FATHER'S NAME First <i>Harrey</i>	Middle <i>S. Rawle</i>	Last <i>Rosalie</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Rosalie Moore</i>	Last <i>Moore</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>	16b. SOCIAL SECURITY NO. <i>215-50-0230</i>	17. INFORMANT <i>Rosalie Moore Rawle, 2507 Old Joppa Rd., Joppa</i>	Address <i>Md</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Extensive hepatic metastasis</i> DUE TO, OR AS A CONSEQUENCE OF <i>metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1830</i> (b) <i>ovarian ca. (primary)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mo</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1750</i>								<i>1/2</i>	
19a. DATE OF OPERATION <i></i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>10</i> MORN. <i>1968</i> Day <i>19</i> P.M. <i></i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>10-26, 1968</i> , to <i>10-27, 1968</i> , that (I) (we) last saw the deceased alive on <i>10-27, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								<i></i>	
22b. SIGNATURE <i>Henry H. Kwolek M.D.</i>								22c. DATE SIGNED <i>10-27-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>HENRY H. KWOLEK M.D.</i>		22e. ADDRESS <i>608-S. UNION AVE. HARRE-DE-GRAVE</i>							
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE <i>Oct. 30, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Camp Chapel Cemetery</i>	23d. LOCATION (City or Town) <i>Perry Hall</i>	(County) <i>Balto</i>	(State) <i>Md</i>			
24. FUNERAL DIRECTOR <i>Howard K. McComas &amp; Son, Abingdon, Md.</i>		ADDRESS <i></i>						25a. REC'D BY REGISTRAR <i>OCT 29 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14481

Items#23b,c,d, FilmG405 10/7/68 km

## CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN:  
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please stamp 2 on page 3.  
 BURIAL: This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Year	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
John Emmett Roberts				October	1, 1968	2P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH December 29, 1872			6. AGE (In years last birthday) 95	YRS.	
7a. BIRTHPLACE (State or foreign country) U.S.A.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Harford Co.,			
10. CITY OR TOWN OF DEATH Bel Air (Rural)	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Forge Hill Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD#1, Box#172			
14. FATHER'S NAME Swift	Middle Roberts	15. MOTHER'S MAIDEN NAME Margaret	Last Telliver				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO. 218-54-2264	17. INFORMANT Daughter (838-4712) Mrs. BESSIE HAYES	Address 1723 Churchville Road Bel Air, Maryland 21014				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Chr. arteriosclerotic cardiovascular disease 12 yr DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201 None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (his hospital) attended the deceased from Oct. 1, 1960, to Oct. 1, 1968, that (I) (we) last saw the deceased alive on Sept. 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Willard P. Hudson		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Oct. 1, 1968		
22d. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.		22e. ADDRESS Phone: 838-3668 Forest Hill, Maryland 21050					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 4, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Kirby Family Cemetery			23d. LOCATION (City or Town) Galax, Grayson Co., Virginia	(County)	(State)
24. FUNERAL DIRECTOR Joseph William Foster Bel Air, Maryland 21014		ADDRESS W. Broadway & Williams	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge			
			OCT 3 1968				

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14482

14475

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Both pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 9:30	
<i>DRUSILLA Mary Rogers</i>					10	25	- 68		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female	White	July 30, 1903		65 YRS.					
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Harford</i>					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				
<i>Harve-de-Grace</i>	<i>Harford Memorial Hospital</i>				<i>Housewife</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	12b. KIND OF BUSINESS OR INDUSTRY				
<i>Delaware</i>	<i>New Castle</i>	<i>Newark</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>P.O. Box 1004</i>	<i>HOMEMAKER</i>				
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost		
<i>Kalob James</i>	<i>Cuthbert</i>	<i>Merrick</i>		<i>Anna</i>			<i>Riley</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT		Address					
No	<i>NONE</i>	Daughter - 368-5644		<i>Mrs. Patricia R. Younger</i>		<i>912 Pickett Lane Newark, Delaware A711</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>551.9</i> <i>CVA &amp; Bronchopneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Arrest</i> " (c) <i>Adv. Surgery (Released Brighter)</i> "									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>5605</i>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from <i>10-14, 1968</i> , to <i>10-25, 1968</i> , that (I) (we) last saw the deceased alive on <i>10-25, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE	<i>W.H. Sadowsky</i>	DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED	<i>10/26/68</i>	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		<i>504 Lewis St. Harford, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town) (County) (State)						
<i>Burial</i>	<i>Oct. 28, 1968</i>	<i>Bel Air Memorial Gardens</i>	<i>Bel Air, Harford Co., Maryland 21014</i>						
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR						
<i>Joseph William Foster</i>	<i>10. Broadway &amp; Williams St. Bel Air, Maryland 21014</i>		<i>OCT 28 1968</i>						
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14483

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 53 P.M.				
<i>Raymond Webster Ruff</i>				10	22	1968					
3. SEX <i>M</i>	4. RACE <i>C</i>	5. DATE OF BIRTH <i>Sept 15, 1898</i>			6. AGE (In years lost birthday) <i>70</i>	YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Harford</i>								
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Harford Bel Air</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>119 Alice Ann St.</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>2nd</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Bel Air</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>119 Alice Ann St.</i>							
14. FATHER'S NAME First <i>Richard</i>	Middle <i>Ruff</i>	Last <i>Ruff</i>	15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i>	Middle <i>Norton</i>	Last <i>Norton</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>219-05-1148</i>	17. INFORMANT <i>Corrine B RUFF Bel Air Md</i>	Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident (Thrombosis)</i>											
4120 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) <i>Hypertensive-Arteriosclerotic C.V. disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
443X											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
MEDICAL CERTIFICATION		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State				
22a. I certify that (I) (this hospital) attended the deceased from <i>9/16</i> , 19 <i>68</i> , to <i>10/22</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/22</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>George T. Stansbury, M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/23/68</i>						
22d. PHYSICIAN'S NAME (Type) <i>George T. Stansbury, M.D.</i>	22e. ADDRESS <i>569 Revolution St. Havre de Grace, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-26-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Harrow Hill Cem Bel Air Har Md</i>	23d. LOCATION (City or Town) (County) (State)								
24. FUNERAL DIRECTOR <i>George W. Title Bel Air Md</i>	ADDRESS <i>Bel Air Md</i>	25a. REC'D. BY REGISTRAR <i>OCT 28 1968</i>	25b. REGISTRAR'S SIGNATURE <i>James Judge</i>								

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FOR STATE  
HEALTH DEPT.



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 with the State Department of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14477

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14484

1. DECEASED NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR	
William Everett Sample				Oct. 8, 1968					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			2d. HOUR	
Male	White	August 30, 1911	57 yrs.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH						
Baltimore Co., Md.	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Harford County,						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Benson				Dog Catcher			Co. Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Maryland	Harford	Bel Air	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1201 Prospect Mill Road					
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost		
H.	Frank	Sample		Florence				Sauers	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT (Wife) 838-3719			ADDRESS 1201 Prospect Mill Rd				
No	212-03-1685	Mrs. Catherine M. Sample Bel Air, Md. 21014							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Multiple Injuries</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
819.9 Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 825.4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. Oct. 8, 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Auto Accident</u>						
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Highway-Benson, Md.</u>	21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
Benson, Harford Co., Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gerald C Palmer</u>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, MD, Bel Air, Md.</u>								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
								ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)	(State)				
Burial	Oct. 11, 1968	Bel Air Memorial Gardens	Bel Air, Harford Co., Maryland	21014					
24. FUNERAL DIRECTOR	ADDRESS <u>West Broadway &amp; Williams Street</u>			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
Joseph William Foster	Bel Air, Maryland 21014			OCT 10 1968	<u>Charles Judge</u>				
VR A15ME (5) 10M REV. 1/68									

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## Lesson 36 - The Past Tense

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14473

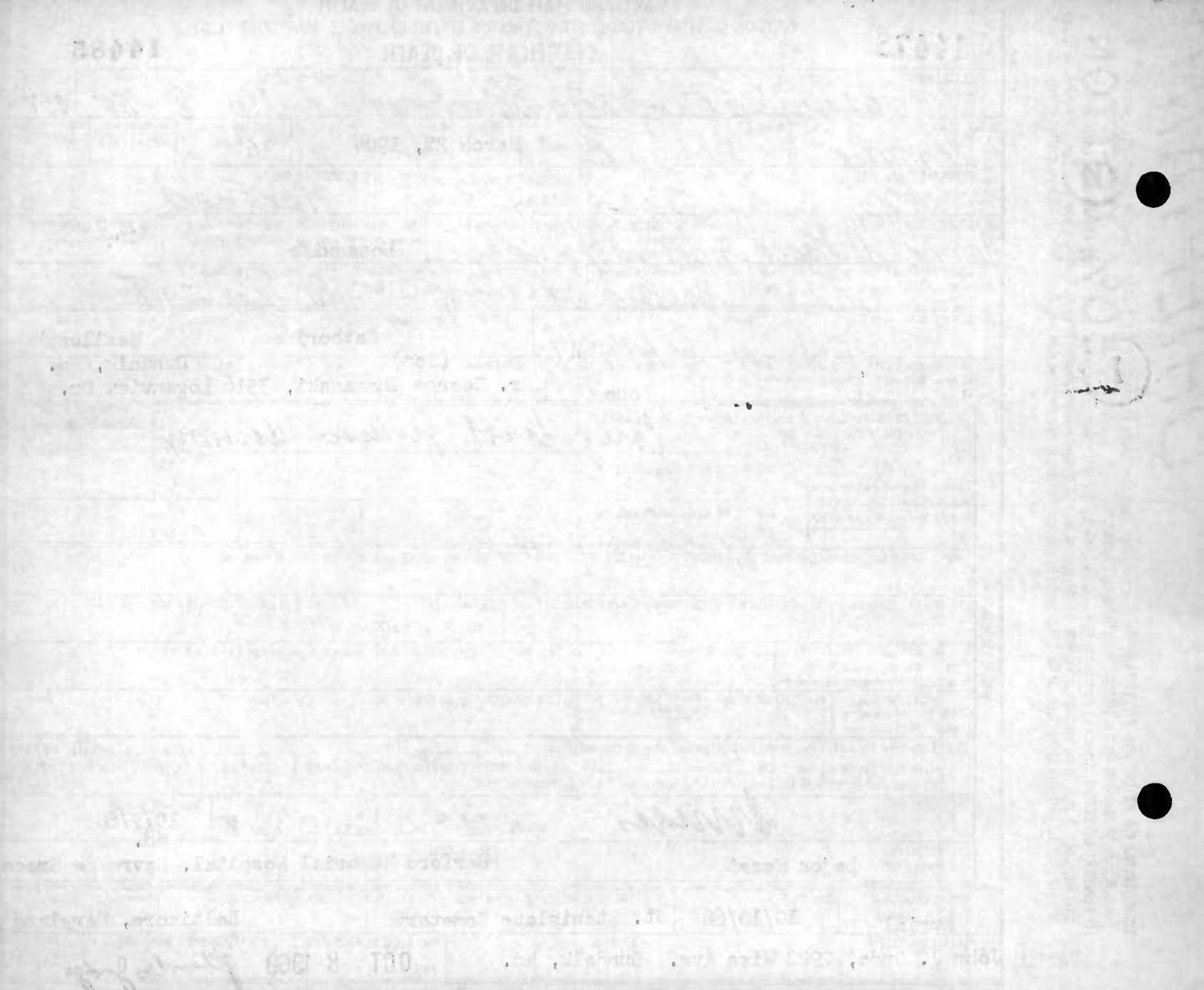
CERTIFICATE OF DEATH

14485

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR	
<i>Gabriella Elizabeth Shamanski</i>					10	26	1968	10:00 AM	
3. SEX <i>Female</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>March 27, 1904</i>		6. AGE (In years last birthday) <i>64</i>		IF UNDER 1 YEAR MONTHS    DAYS    HOURS YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Pa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Hanford</i>			
10. CITY OR TOWN OF DEATH <i>Havre-de-Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hanford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Hanford</i>		13c. CITY OR TOWN <i>Darlington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>St. 287, 218</i>	
14. FATHER'S NAME First <i>Joseph</i>		Middle <i>Selwaski</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Catherine</i>		Middle	Last	Wasileczyk	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT (Son) <i>Mr. George Shamanski, 3516 Loganview Dr.</i>		Address <i>Dundalk, Md.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conq. heart failure decomps.</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) _____</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (c) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4341</i></p>									
19a. DATE OF OPERATION <i>4341</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
<p>22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <i>Lajos Mezei</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED <i>10/7/68</i>
22d. PHYSICIAN'S NAME (Type) <i>Lajos Mezei</i>		22e. ADDRESS <i>Hanford Memorial Hospital, Havre de Grace</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/10/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Stanislaus Cemetery</i>		23d. LOCATION (City or Town) <i>Baltimore, Maryland</i>		(County)	(State)
24. FUNERAL DIRECTOR <i>John J. Duda, 7922 Wise Ave.</i>		ADDRESS <i>Dundalk, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Duda</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14486

**1** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14479		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										14486												
1. DECEASED NAME (Type or print)		McLie Ross Singleton			Lost		20. DATE OF DEATH		Month		Doy		Year		2b. HOUR									
3. SEX		Female			4. RACE		White			5. DATE OF BIRTH		SEPT. 18, 1902			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		IF UNDER 24 HRS. HOURS		MIN.	
7a. BIRTHPLACE (State or foreign country)		Md.			7b. CITIZEN OF WHAT COUNTRY?		USA			8. MARRIED		<input type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH		Harford.						
10. CITY OR TOWN OF DEATH		Hayne-de-Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		Harford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		Housewife			12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		Md.			13b. COUNTY		Harford			13c. CITY OR TOWN		White Ford			13d. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		Main St.		
14. FATHER'S NAME		First Benjamin			Middle Ross		Last			15. MOTHER'S MAIDEN NAME		First Ida			Middle Mae		Last Lee			Address				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		No			16b. SOCIAL SECURITY NO.		215-32-8279			17. INFORMANT		K.C. SINGLETON, WHITEFORD, MD.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Severe Cardiac Decompensation			DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease					(c)					(d)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease					(c)					(d)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)		Uncontrolled Diabetes Mellitus			21. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town			County		State		
22a. I certify that (I) (this hospital) attended the deceased from 10 - 2, 1968, to 10 - 5, 1968, that (I) (we) last saw the deceased alive on 10 - 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					22b. SIGNATURE Dante U. Monakil, M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Oct 5, 1968			22d. PHYSICIAN'S NAME (Type)		DANTE U. MONAKIL			22e. ADDRESS Leslie Rd. Haure de Grace, M.D.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10/8/68			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Nebo Cemetery		23d. LOCATION (City or Town) Delta			(County) York		(State) Pa.			23e. ADDRESS Delta, Pa.									
24. FUNERAL DIRECTOR		ADDRESS John H. Harkins			25a. REC'D BY REGISTRAR DATE OCT 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge																	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14487

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Marian</i>	Middle <i>Standiford</i>	Last <i>E.</i>	2a. DATE OF DEATH Month <i>Oct.</i>	Day <i>19</i>	Year <i>1968</i>	2b. HOUR <i>6:05 A.M.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>Jan. 10, 1880</i>	6. AGE (In years last birthday) <i>88</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>			IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>HARFORD</i>			
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Magistrate</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>HARFORD</i>	13c. CITY OR TOWN <i>Darlington</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	13e. STREET AND NUMBER <i>RD#2, Box 2-1A</i>			
14. FATHER'S NAME First <i>Charles</i>	Middle <i>H.</i>	Last <i>Standiford</i>	15. MOTHER'S MAIDEN NAME First <i>Euphemia</i>	Middle <i>Whitelock</i>	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>215-12-5959A</i>	17. INFORMANT <i>Miss Sarah Standiford, Darlington, Md.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Cardiac Decompensation</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4221</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Cardiovascular Disease, Class IV, E.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pneumonia - rt. lung + diabetes mellitus</i>							
19a. DATE OF OPERATION <i>1/1/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i></i>					
21d. INJURY OCCURRED While at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>10/18/68</i> to <i>10/19/68</i> that (I) (we) last saw the deceased alive on <i>10/19/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward C. Loo, M.D.</i>	22c. DEGREE <i>B.S., M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/20/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>	22e. ADDRESS <i>Havre de Grace, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 22, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Darlington Cemetery</i>	23d. LOCATION (City or Town) <i>Darlington</i>	(County) <i>Harfard</i>	(State) <i>Md.</i>		
24. FUNERAL DIRECTOR <i>Lee A. Patterson &amp; Son, Perryville, Md.</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i>OCT 24 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14488

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <b>FRANKLIN</b>	Middle <b>B.</b>	Lost <b>STEWART</b>	2a. DATE OF DEATH Month <b>October</b>	Day <b>5,</b>	Year <b>1968</b>	2b. HOUR <b>3:20 a.m.</b>				
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>February 25, 1913</b>		6. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR MONTHS <b>55</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>				
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Harford</b>								
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Harford Memorial Hosp.</b>		12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Janitor</b>	13b. COUNTY <b>Harford</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Janitorial</b>	13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>Route #1, Box 57</b>	
14. FATHER'S NAME First <b>Doward</b>	Middle <b>Stewart</b>	Last <b>(D)</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b>	Middle <b>Rebecca</b>	Last <b>Kell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. (If give war or dates of service) <b>218-07-3986</b>	17. INFORMANT <b>Mary E. Turner, R.D. 1, Aberdeen, Md. 21001</b>	Address <b>24 hr.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 yr.</b>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Bronchial (Alergic) Asthma</b>											24 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>241 X</b>											
19a. MEDICAL CERTIFICATION DATE OF OPERATION <b>241 X</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <b>Not while at work</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>1-7 - 1968</b>								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>10-4-1968</b>	21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>10-4-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.											22c. DATE SIGNED <b>10-5-68</b>
22b. SIGNATURE <b>Peter P. Rodman, M.D.</b>		22d. PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>	22e. ADDRESS <b>8 Law St. Aberdeen, Maryland 21001</b>	22f. DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8 Oct. 68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Forest Hill, Har. Md.</b>					
24. FUNERAL DIRECTOR <b>Tanning Funeral Home, Aberdeen, Md. 21001</b>		ADDRESS			25a. REC'D BY REGISTRAR <b>OCT 7 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14482

14489

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brevin Nursing Home</b>		d. STREET ADDRESS <b>Deerfield Road</b>	
3. NAME OF DECEASED (Type or print) <b>MARY JANE SWIFT</b>		First <b>MARY</b>	Middle <b>JANE</b>
4. DATE OF DEATH <b>October 3, 1968</b>	Month Day Year	Last <b>SWIFT</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Oct. 20, 1886</b>		9. AGE (In years last birthday) <b>81 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John C. Hill</b>		14. MOTHER'S MAIDEN NAME <b>Melissa Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-52-2119</b>	
17. INFORMANT <b>Mrs. Marie Akers</b>		Address <b>Darlington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia + Ulceric</b> DUE TO <b>4409</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterosclerosis</b> DUE TO <b>4500</b> (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>36 hr</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1947</b> to <b>Oct 3, 1968</b> that (I) (we) last saw the deceased alive on <b>Oct 3 1968</b> , and that death occurred at <b>9:30 pm</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dudley Phillips</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Dudley Phillips MD</b>		22d. ADDRESS <b>Darlington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 7, 1968</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Dublin Southern Cemetery Dublin, Harford, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>John H. Harkins</b>		ADDRESS <b>Delta, Pa.</b>	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE CO. <b>OCT 8 1968</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14483

14490

1. DECEASED NAME (Type or print)	First GEORGE	Middle T.	Lost TOMASKY	2a. DATE OF DEATH Month October	Day 3	Year 1968	2b. HOUR 11:15 pm.	
3. SEX Male	4. RACE Caucasian	S. DATE OF BIRTH 1 June 1891	6. AGE (In years last birthday) 77	IF UNDER 1 YEAR MONTHS YRS.			IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford					
10. CITY OR TOWN OF DEATH Aberdeen	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 453 W. Bel Air Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Personnel Officer	12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 453 W. Bel Air Avenue				
14. FATHER'S NAME Anthony	First M.	Middle Tomasky	15. MOTHER'S MAIDEN NAME Henrietta	Middle C.	Lost Fleisher	(D)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-22-0555	17. INFORMANT Bessie Tomasky, Aberdeen, Maryland	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.				Coronary occlusion				
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic myocarditis								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
4201		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 2/6, 1961, to 4/10, 1968, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>A.L. Lewis, M.D.</i>				DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 1968	
22d. PHYSICIAN'S NAME (Type) A.L. Lewis, M.D.				22e. ADDRESS 214 N. Union Ave. Havre de Grace, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7 Oct. 68	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery	23d. LOCATION (City or Town) W. Long Branch, New Jersey	(County)	(State)		
24. FUNERAL DIRECTOR Tarrung Funeral Home, Aberdeen, Md. 21001				ADDRESS	25a. REC'D BY REGISTRAR OCT 7 1968	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14484

CERTIFICATE OF DEATH

14491

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of its death.

1. DECEASED-NAME (Type or print)		First <b>Carrie</b>	Middle <b>Ann</b>	Lost <b>Vaughn</b>	2a. DATE OF DEATH Month <b>Oct</b>		Day <b>18</b>	Year <b>1968</b>	2b. HOUR <b>1020A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH <b>18 Oct 1968</b>		6. AGE (In years last birthday) <b>YRS.</b>		IF UNDER 1 YEAR MONTHS <b>—</b>		IF UNDER 24 HRS. MONTHS <b>—</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Harford</b>						
10. CITY OR TOWN OF DEATH <b>AberdeenProvingGround</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>US Kirk Army Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Harford</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		13e. STREET AND NUMBER <b>B-8-2 Lincoln Ave</b>						
14. FATHER'S NAME <b>Harry</b>		First <b>W</b>	Middle <b>Vaughn</b>	Lost	15. MOTHER'S MAIDEN NAME <b>Carolyn</b>		Middle <b>—</b>	Last <b>Bowers</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Saw as * 14- B-8-2 Lincoln Ave.</b>		Address <b>Aberdeen Md.</b>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b>												
7701 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) <b>Abruptio placentae</b> stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
2615		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>18 Oct 1968</b> , to <b>18 Oct 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>18 Oct 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.												
22b. SIGNATURE <b>Richard H. Heller, M.D.</b>		22c. DEGREE <b>MD.</b>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		DATE SIGNED <b>18 Oct 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>RICHARD H HELLER, CPT, MC</b>		22e. ADDRESS <b>US KIRK ARMY HOSPITAL, APG, MD.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/23/1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Plainville Cemetery</b>		23d. LOCATION (City or Town) <b>Plainville Indiana</b>		(County) <b>Indiana</b>		(State)		
24. FUNERAL DIRECTOR <b>Whitson Macomber Sr.</b>		ADDRESS <b>Tarris Funeral Home Aberdeen Md.</b>		25a. REC'D BY REGISTRAR <b>ACT 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Heller</b>						

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14492

FOR STATE  
HEALTH DEPT.

Any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page  
5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Lost (WAGONET)	2o. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> Oct 27 1968 M	2b. HOUR
LEONIE		Wagoner				
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years) <i>Sept. 5, 1914</i> (54) lost birthday	7. IF UNDER 1 YEAR MONTHS OAYS HOURS MIN.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford
			54 yrs			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford
Virginia		U.S.A.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY Homemaker
HAUTE DE GRACE		(DOA) Harford Memorial Hospital		Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
Maryland		Harford	Darlington	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Franklin Church Road	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First
		ISAAC		Reedy	BETTY	Blair
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT (Husband) +57-4691 Mr. REEBER K. WAGONET		ADDRESS RFD #2, Box #80 Darlington, Maryland 21034
No		164-18-3706				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Disease</u> DUE TO, OR AS A CONSEQUENCE OF 4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 443X						
19o. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21o. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town County State
22o. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>Verold C Palmer</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Oct 27 1968
EXAMINER'S NAME (Type) <u>Verold C Palmer MD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)						
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 30, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Darlington Cemetery		23d. LOCATION (City or Town) (County) (State) Darlington, Harford Co., Maryland
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25o. REC'D BY REGISTRAR DATE OCT 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14493

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14486		CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR						
Mirriam				Watson	October 11, 1968		5:30 P.M.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR					
Female		White		10/18/1874		99 yrs.		MONTHS	DAYS	IF UNDER 24 HRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
N.J.		USA				Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		Harford Memorial Hosp., Havre de Grace				Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md		Harford		Havre de Grace		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		520 W. FRANKLIN ST.					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last				
Edward McCormons					Lydia Deaver								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		64 Dahlia Turner Lydia G. Bunkeroff Dailey Pa				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		unk.											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Dehydration</u>													
DUE TO, OR AS A CONSEQUENCE OF <u>malnutrition</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>underlying</u>													
DUE TO, OR AS A CONSEQUENCE OF <u>hypertension + Generalized Arteriosclerosis</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)													
4500													
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-6, 1968</u> , to <u>10-11, 1968</u> , that (I) (we) last saw the deceased alive on <u>10-11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		Dante U. Monakil MD		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		DANTE U. MONAKIL, M.D.		22e. ADDRESS		23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)	
				211 N. Union Ave. Havre de Grace, Md		10/14/68		Angel Hill		Harford Co. Harford Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REGISTRY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Ferryman & Son, Havre de Grace, Md				OCT 16 1968		Charles Judge							
DATE													

CRAB

10-10-11

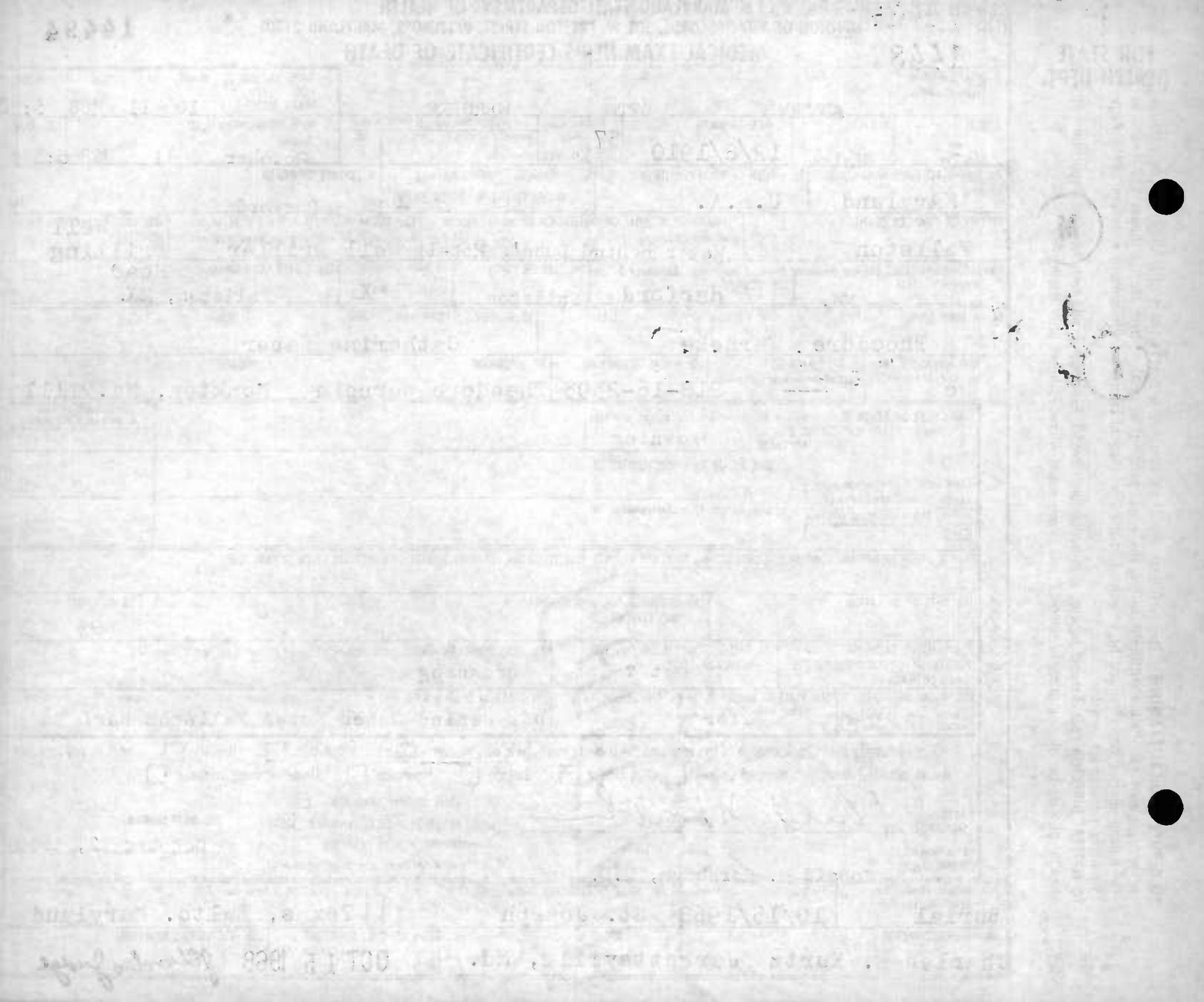
each 0.100

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or Print)		First			Middle		Last			2a. DATE KNOWN OF ESTI- DEATH MATED				
		ANTHONY			OTTO		WERNEKE			<input checked="" type="checkbox"/> Month 10 Day 11 Year 1968				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years at birthday)		IF UNDER 1 YEAR MONTHS      DAYS		IF UNDER 24 HRS. HOURS      MIN		2b. HOUR 5:58		
Male		White		12/8/1910		57 yrs.						2d. HOUR 5:58pm		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		<input type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> WIDOWED		<input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Harford		
Maryland		U.S.A.												
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Water behind Dube's Motel		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Well Driller		12b. KIND OF BUSINESS OR INDUSTRY Drilling								
Md.		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Fallston, Md.		Road				
14. FATHER'S NAME Theodore Werneke		15. MOTHER'S MAIDEN NAME Catherine Naber												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-16-2393		17. INFORMANT Theodore Werneke		ADDRESS Monkton, Md. 21111								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9298														
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. Oct ? 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Drowning										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Water		21f. LOCATION Street or R.F.D. No.      City or Town      County      State US1 behind Dubes Motel Fallston Harf Md										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Ronald N. Kornblum, M.D.														
ACTUAL SIGNATURE RONALD N. KORNBLUM, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED October 12, 1968								
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/15/1968		23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph		23d. LOCATION (City or Town) Texas, Balto. Maryland								
24. FUNERAL DIRECTOR Charles E. Kurtz		ADDRESS Jarrettsville, Md.		25a. REC'D BY REGISTRAR OCT 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge								
VR AISMED 1 10M REV. 1/68														



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
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14488 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

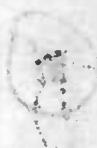
14495

Item#23c,d, FilmgL MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
<i>Howard Leroy Wert</i>				<input checked="" type="checkbox"/>	Oct	8	1968	M
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			2d. HOUR
M	W	7-18-38	30 YRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. COUNTY OF DEATH				
FLETCHER, OHIO	USA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Harford				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
EDGEWOOD MD.	RT. 40			SOLDIER	US ARMY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
ALBRECHEN PRV GND	HARFORD	ABERDEEN	<input checked="" type="checkbox"/> NO	C 4A, 1st BN USAOC 85				
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
ERNEST				HELEN LUCILLE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS					
Yes	31658-84768291-30-8959	ERNEST WERT	ALEXANDRIA, VA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
955X	GSW carburetor							
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.	(b)							
	DUE TO, OR AS A CONSEQUENCE OF							
	(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)								
976X								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
	EDGECOM Motor Sales	Shot Self	EDGECOM HTZ	Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
Ronald C Palmer								
ACTUAL SIGNATURE	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)	ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)	(State)			
REMOVAL	10/7/11-68	Fletcher Cemetery	Fletcher					
24. FUNERAL DIRECTOR	ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
G. Robert Grant	NORTH EAST, MD			OCT 14 1968	George J. Grant			
GRANT FUNERAL HOME								

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RECORDED MAIL  
MURKIN, DON JAMES TOWNSHIP OF THE GOOD SHEPHERD  
PA 17439-0238 P.O. BOX 238



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FOR STATE  
HEALTH DEPT.

14489 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a, Form GL05-10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14496

1. DECEASED NAME (Type or Print)	First <b>PHILLIP</b>	Middle <b>DARRELL</b>	Lost <b>WHITELY</b>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month Oct. 2	Day 168	Year M	2b. HOUR				
3. SEX <b>Male</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>Oct. 15, 1951</b>	6. AGE (in years last birthday) <b>16</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	IF UNDER 24 HRS. DAYS <input type="checkbox"/>	HOURS <input type="checkbox"/>	MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month Oct.	Day 1/2 Year 1968	2d. HOUR 11:07PM		
7a. BIRTHPLACE (State or foreign country) <b>W.Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <b>Harford</b>	10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA - Harford Memorial Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Joppa</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <b>1513 Cochran Road</b>								
14. FATHER'S NAME <b>Billy</b>	First <b>G.</b>	Middle <b>Whitely</b>	Lost <input type="checkbox"/>	15. MOTHER'S MAIDEN NAME <b>Gay</b>	First <b>E.</b>	Middle <b>Epperly</b>	Lost <input type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>215-56-1336</b>	17. INFORMANT <b>Billy G. Whitely, 1513 Cochran Road, Joppa,</b>	ADDRESS <b>Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture skull</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. <b>8199</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7254</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) <b>Auto accident</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Joppa, Md.</b>	21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Gerald C Palmer</i>	M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>	18-1 Air m/						
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED <b>Oct. 3, 1968</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>								23b. DATE <b>Oct. 5, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or Town) <b>Bel Air</b>	(County) <b>Harford</b>	(State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>	ADDRESS	25a. REGD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									
		DATE	OCT 7 1968									

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John C. H. Stagg, *The Union War Cabinet* (Princeton, NJ: Princeton University Press, 1989), pp. 11–12.

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## VISIT

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## Little stories

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823 E. 35<sup>th</sup>

W. H. G. - W. H. G.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14497

FOR STATE  
HEALTH DEPT.

1 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil. (Item 11, Part 8.) Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

2 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First	Middle	Last	20. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR	
Fay J. F. Williams				<input checked="" type="checkbox"/> 10	21	1968	M		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years (on birthday))	IF UNDER 1 YEAR	IF UNDER 24 HRS.			2d. HOUR	
M	W	11-7-17	50 yrs.	MONTHS	DAYS	HOURS	MIN		
7. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
Maryland		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/>	Harford			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Harford City		St. Mary's Hospital		Supply dept.		Obstetrics			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY, TOWNSHIP	13e. STREET AND NUMBER			
Md.		Harford		Harford	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	875 075 50 S.			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
Charles F. Williams				Mary Snapp					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.		17. INFORMANT	ADDRESS					
Yes	314-09-8048		Mrs. Barbara Weaver, Perryville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending DUE TO, OR AS A CONSEQUENCE OF 890 X									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9160									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?					
19c. MEDICAL CERTIFICATION		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 10-24 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Burned in house fire					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State Havre de Grace Harf Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>									22b. DATE SIGNED 10-24-68
ACTUAL SIGNATURE Gerald E. Palmer									CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Removal 10/25/68		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City or Town) Hagerstown		(County) (State)	
24. FUNERAL DIRECTOR		ADDRESS Zel G. Patterson Son, Perryville, Md.		25a. RECD BY REGISTRAR DATE OCT 31 1968		25b. REGISTRAR'S SIGNATURE j Charles Judge			

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FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Roger X  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14498		
1. DECEASED-NAME (Type or Print)			First	Middle	Last	20. DATE KNOWN <input type="checkbox"/> Month Day Year			2b. HOUR					
Margaret Jane Williams						OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10 24 1968			M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Oct Day 24 Year 1968				
F		W		12-13-19		48				2d. HOUR				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Harford						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Havre de Grace			875 Otsego St			Clerk			Laundries					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
Md			Harford			No		875 Otsego St						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Eugene			B.	Bowers		Flora N. Hoffman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
(If yes, give war or dates of service)			220-09-7237			Mrs. Barbara Weaver, Perryville, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1P890X Poisoning due to CO												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9160														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 10-24 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Burned in house fire			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			Havre de Grace Harf Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)	10-24-68	
ACTUAL SIGNATURE Gerald C. Palmer			EXAMINER'S NAME (Type) Gerald C. Palmer MD			22b. DATE SIGNED								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 10/25/68			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) (County) (State)					
Removal			10/25/68 Rest Haven Cemetery Hagerstown											
24. FUNERAL DIRECTOR			ADDRESS Lee J. Patterson Son, Perryville			25a. RECEIVED BY REGISTRAR DATE OCT 31 1968			25b. REGISTRAR'S SIGNATURE					
									Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

14492

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14499

1. DECEASED-NAME (Type or Print)		First <b>WESLEY</b>	Middle <b>NICHOLAS</b>	Lost <b>ZAWADSKY</b>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month <b>Oct.</b>	Day <b>15</b>	Year <b>68</b>	2b. HOUR <b>1:40 M</b>				
3. SEX <b>Male</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>July 7, 1923</b>	6. AGE (In years last birthday) <b>45</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	HOURS <b>0</b>	MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>Oct.</b>	Day <b>15</b>	Year <b>1968</b>	2d. HOUR <b>1:40 M</b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Harford</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Production Planning Off. US-govt.</b>					
10. CITY OR TOWN OF DEATH <b>Bel Air</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1212 Vermont Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Production Planning Off. US-govt.</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Bel Air</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>1212 Vermont Rd.</b>
14. FATHER'S NAME <b>Nicholas</b>		Middle <b>--</b>	Lost <b>Zawadsky</b>	15. MOTHER'S MAIDEN NAME <b>Bertha</b>		Middle <b>--</b>		Lost <b>Johana</b>		Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>WWII</b>		17. INFORMANT <b>Elizabeth J. Zawadsky, 1212 Vermont Rd., Bel Air</b>		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF <b>4109</b> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <b>4201</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>P.M.</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>307 Hickory Ave.,</b>		City or Town <b>Bel Air</b>		County <b>Harford</b>		State <b>Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Philip W. Heuman</i>		M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>Oct. 15, 1968</b>					
EXAMINER'S NAME (Type) <b>Philip W. Heuman, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county) <b>307 Hickory Ave.,</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City or Town) <b>Bel Air</b>		(County) <b>Harford</b>		(State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>		ADDRESS				25a. REGD BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
25c. DATE <b>OCT 17 1968</b>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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